

MercyOne Oelwein Medical Center

RULES AND REGULATIONS

April 1, 2021

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ARTICLE I ADOPTION OF RULES AND REGULATIONS

The Medical Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within the Medical Staff Bylaws.

The rules and regulations are intended to facilitate the effective and efficient discharge of the responsibilities and duties of the Medical Staff, ensure the conduct of each staff member and Allied Health Professional is consistent with the Mission, Vision, and Values and other policies of MercyOne Oelwein Medical Center. These rules and regulations are a part of the Medical Staff Bylaws, except that they may be amended or repealed by a majority vote of the Executives of the Medical Staff, by the General Medical Staff at any regularly scheduled meeting without previous notice, or at any special meeting after previous notice. Changes become effective upon approval of the Board of Directors.

ARTICLE II ADMISSION / DISCHARGE / TRANSFER

SECTION 1: ACCEPTANCE OF ALL PATIENTS

1. The hospital shall accept all patients for care and treatment.

SECTION 2: ADMISSION BY MEMBER OF MEDICAL STAFF ONLY

1. Only a member of the medical staff may admit a patient to the hospital. All practitioners shall abide by the admitting policy of the hospital.

SECTION 3: PROVISIONAL DIAGNOSIS REQUIRED FOR ADMISSION

1. Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible.
2. Emergency shall be defined as potential for loss of life and/or limb.

SECTION 4: PHYSICIAN RESPONSIBILITY IN ATTENDING ADMITTED PATIENTS

1. A member of the Medical Staff shall be responsible for the following: the medical care and treatment of each patient in the hospital; ensuring that a daily visit, or more frequent if warranted by the patient's condition, by at least one physician, nurse practitioner, or physician assistant occurs, to include a progress note in the electronic health record; prompt completeness and accuracy of the medical record; providing necessary special instructions; and transmitting reports of the condition of the patient to other physicians as appropriate and necessary, the referring physician, and to the patient and his/her family.
2. Whenever these responsibilities are transferred to another member of the Medical Staff, a note covering the transfer of responsibility shall be documented in the medical record.

SECTION 5: PATIENT INFORMATION FOR SAFETY

1. The admitting physician is responsible to provide information about the patient to assure the protection of the patient from self-harm or harm to others, if the patient is determined to be a source of danger.

SECTION 6: PATIENT TRANSFERS

1. Transfer priorities shall be as follows:
 - A. Emergency room to appropriate patient bed
 - B. Monitored bed to general care unit

2. Patient transfers may occur only with the approval of the responsible Medical Staff member and in compliance with the Wheaton Franciscan Healthcare *Patient Transfer Policy*.

SECTION 7: VALIDITY OF ADMISSION OR DISCHARGE FROM MONITORED BEDS

1. The appropriateness of admission and/or discharge to or from the monitored bed is based on criteria approved by the Medical Staff. Any question regarding the validity of the admission or discharge shall be directed to the President of the Medical Staff.

SECTION 8: WHO MAY ADMIT AND MANAGE PATIENTS IN MONITORED BEDS

1. Privileges to manage patients and perform procedures in monitored beds may be granted based on training, experience and demonstrated ability, as recommended by the Medical Staff, Professional Activities Committee, and the Board of Directors.
2. The **Admitting** physician shall designate the **Primary/Attending** physician in the admitting orders. The **Primary** physician is responsible for all aspects of the management of patient care including designating the lines of responsibility and communicating with all physicians, patient and family. The **Primary** physician is to be informed of all changes in patient status and results of medical interventions.
3. All patients will be seen by their **Primary** and/or **Consulting** physician and a progress note recorded daily, or more frequently, if the patient's condition warrants.
4. The physician managing the patient will be responsible for discharging the patient from the unit.

SECTION 9: DISCHARGE OF PATIENT RESPONSIBILITIES [AGAINST MEDICAL ADVICE (AMA)]

1. Patients shall be discharged only on the order of the attending member of the Medical Staff. Should a patient leave the hospital against the advice of the attending Medical Staff member, or without discharge orders, a notation of the incident shall be made in the patient's medical record, and the effort made to obtain the patient's waiver of liability for doing.

ARTICLE III MEDICAL RECORDS

SECTION 1: REQUIRED ADMISSION/CONTINUED STAY DOCUMENTATION

1. The attending Medical Staff member is required to document a plan of care which supports the medical necessity of admission and continued stay. This documentation must contain:
 - A. an adequate record of the reason for admission and continued hospitalization
 - B. the clinical goals/outcomes and treatment plan
 - C. plans for post-hospitalization
2. The attending Medical Staff member must document justification of the necessity for continued hospitalization, including an estimate of the number of additional days of stay and reason thereof.

SECTION 2: PRACTITIONER'S RESPONSIBILITY FOR ADEQUATE MEDICAL RECORD

1. Documentation. All documentation in the medical record must be in electronic format. Practitioners are encouraged to use Powernotes/Dynamic Documentation or Dragon voice recognition. An exception to this rule occurs during system downtimes. Practitioners should follow downtime protocols during planned or unplanned periods of downtime.
2. The appropriate member of the Medical Staff shall be responsible for the preparation of a complete medical record for each patient. The record content shall be pertinent and current. At a minimum, the record shall include:
 1. Identification data
 2. Chief complaint
 3. History of present illness
 4. Complete personal, social, past and family history
 5. Review of systems
 6. Physical examination
 7. Provisional diagnosis
 8. Reports of consultations
 9. Clinical laboratory, imaging and other diagnostic results
 10. Any medical or surgical treatment
 11. Operative report
 12. Pathological findings
 13. Progress notes
 14. Final diagnosis
 15. Condition on discharge
 16. Discharge note/clinical resume including:
 - the reason for admit
 - pertinent findings
 - interventions relative to the findings
 - condition on discharge
 - instructions to the patient and/or family, particularly in regard to

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activity, medication, diet **and** post-hospitalization care
- autopsy report, when performed.

SECTION 3: PHYSICIAN DEFINITIONS

1. The **Primary/Attending** physician will be responsible for all aspects of management of patient care including designating the lines of responsibility and communicating with all physician, patient and family. The **Primary/Attending** physician is to be informed of all changes in the patient status and results of medical interventions.
2. The **Admitting** physician shall designate the **Primary/Attending** physician in the admitting orders.
3. The **Consultant** is that physician called in on a case to give professional advice.
4. The **personal** physician is the physician regularly called by the family to care for the patient in times of medical need.
5. The **Admitting** physician can be the **Personal, Attending/Primary** physician or the Consultant.

SECTION 4: PROGRESS NOTE REQUIREMENTS

1. Pertinent progress notes shall be recorded at the time of observation or admission, sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems shall be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatments. For all patients in the acute care hospital, progress notes shall be recorded at least daily and, more frequently, if indicated, in critically ill patients, especially if there is difficulty in diagnosis or treatment. A Nurse Practitioner and/or a Physician Assistant may complete the daily progress note requirement on behalf of the supervising Attending of Record.
2. Progress notes shall be recorded at least once every seven (7) days, more frequently if indicated, for patients with a Skilled Nursing level status.
3. Progress notes shall be recorded on admission to the Long Term Care unit, with a follow-up note in thirty (30) days, another in thirty (30) days, and then in a sixty (60) day pattern.

SECTION 5: AUTHENTICATION OF THE MEDICAL RECORD

1. All clinical entries in the patient's record shall be authenticated by the Medical Staff member authorized or who made the entry. Medical Staff members may not authenticate entries in the patient's medical record for other members of the Medical Staff.

SECTION 6: SYMBOLS AND ABBREVIATIONS

1. The Medical Staff Executive Committee has approved the use of abbreviations and symbols in accordance with the Wheaton Franciscan Healthcare Abbreviations and Symbols Policy and Procedure. Unapproved symbols and abbreviations should not be used in the medical record.

SECTION 7: FINAL DIAGNOSIS RECORDING

1. A final diagnosis shall be recorded in full, without the use of symbols or abbreviations, by the responsible Medical Staff member at the time of discharge of all patients. Medical Staff members shall work in cooperation with the Health Information Management department staff to ensure timely and accurate documentation, sequencing of final diagnoses and procedures and completion of attestation statements. Diagnoses may be recorded in the final progress note, discharge summary, or attestation report.

SECTION 8: DISCHARGE SUMMARIES

1. A discharge summary shall be documented on all inpatients, psychiatric patients and observation patients that are in the hospital more than 48 hours.
2. The discharge summary should summarize the reason for hospitalization, significant findings, procedures performed, treatment rendered, the outcome of hospitalization, the condition of the patient on discharge, and any specific instructions given to the patient and/or family, i.e.,
 - A. activity
 - B. medications
 - C. diet
 - D. the disposition of the case
 - E. instructions for post hospital care.The content of the summary shall be sufficient to justify the diagnosis and warrant the treatment and the end result.
3. Discharge summaries will be completed on all inpatient deaths.
4. A discharge summary is required following any acute care stay prior to and following a swing-bed admission and discharge.

SECTION 9 : ACCESS TO MEDICAL RECORDS BY MEDICAL STAFF

1. Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study, research and review consistent with preserving the confidentiality of personal information concerning the individual patients. The Chief of Staff/President of the Medical Staff, the Chief Medical Officer and the Manager of Health Information Management shall approve all such projects.
2. Former members of the Medical Staff shall be permitted access to the medical records of their patients. Requests for such access to records shall be specified in writing for each individual case and authorized by the Chief Medical Officer, or designee, on the former member's request.

SECTION 10: COMPLETION OF THE MEDICAL RECORD

Quality patient care requires that all medical records be completed in a timely fashion, in accordance with applicable law, regulations and standards. A medical record will be considered overdue when it has not been completed within twenty-three (23) days after discharge.

- A. Practitioners will be subject to the following procedure regarding delinquent medical records:
 1. Medical records of all discharged patients must be completed within twenty-three, (23) days after discharge. A verbal notification will be provided to the provider or his/her nurse one week prior to the twenty-third (23) day. If not completed within said twenty-three (23) days, another verbal notification will be provided to the practitioner or his/her nurse indicating the need to go online to complete charts, and that his or her privileges will be automatically suspended if such records are not completed within seven (7) days of the notification.
 2. If the record(s) identified in the notice of delinquency are not completed within thirty (30) days of discharge, a notice of automatic suspension will be sent to the Practitioner, suspending the Practitioner's clinical privileges until such time as the delinquent records have been completed. A copy of this notice will be placed in the Practitioner's Professional File. Such suspension shall be effective as of the date of mailing. A suspension for delinquent medical records does not require reporting to the National Practitioner Data Bank or entitle the affected Practitioner to any of the hearing and appeal rights otherwise afforded under the Medical Staff Bylaws. Reactivation of the suspended clinical privileges will require completion of the medical record(s).
 3. A list of Practitioners with delinquent medical records may be posted in physician lounges and the Health Information Management department, with copies distributed to the Vice President of Medical Affairs, the appropriate department chair, and the manager of the Health Information Management department.

4. At the discretion of the Hospital Administrator or the Medical Staff President (Vice President if the situation involves the Medical Staff President), flexibility may be provided for vacations or illnesses of seven (7) days' duration or longer, or for other extenuating circumstances. Physicians should provide seven (7) days' prior notification to the Health Information Management department of any such circumstances.
- B. During an automatic suspension for delinquent medical records, a Practitioner may continue with the medical care of: emergency admissions and any patients who were under his or her care in the hospital at the time of the suspension.
- C. If a practitioner has been suspended for delinquent medical records three (3) occurrences in any 12 consecutive months, or if one (1) suspension for delinquent medical records lasts longer than ninety (90) days, reactivation of suspended Medical Staff Clinical Privileges will be arranged and conducted during normal HIM business hours only after:
 1. Verification of completion of the delinquent medical record(s), and
 2. The practitioner appears before the Executive Committee for consideration of additional disciplinary action or corrective action, to include possible dismissal from the Medical Staff. If the Practitioner is dismissed from the Medical Staff on this basis, s/he must apply and be processed as a new applicant for initial membership and privileges in order to re-join the Medical Staff

SECTION 11: EMERGENCY MEDICAL RECORDS

1. An appropriate medical record shall be kept for every patient receiving emergency services and be incorporated in the patient's hospital record, if applicable. The record shall include:
 - A. Adequate patient identification
 - B. Time of the patient's arrival, means of arrival, and by whom transported
 - C. Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to arrival in the hospital
 - D. Significant clinical, laboratory and imaging findings
 - E. Diagnosis
 - F. Treatment given
 - G. Condition of the patient on discharge or transfer
 - H. Final disposition, including instruction given to the patient and/or his family, relative to necessary follow-up care.
2. Each available record shall be authenticated by the physician or Allied Health Professional in attendance, who is responsible for its clinical accuracy, prior to the conclusion of their next worked shift.

SECTION 12: CONSULTATION DOCUMENTATION

1. The consultant must enter brief information in the medical record at the time of consult so all caregivers in an emergency with the patient are aware of the recommendation of the consulting physician. A full report should be entered into the record soon after the consultation.

SECTION 13: CONSENT FOR RELEASE OF PATIENT INFORMATION

1. Written consent of the patient or in the case of a minor, a parent or guardian, is required for release of medical information to persons not otherwise authorized to receive this information.

SECTION 14: GENERAL CONSENT FORM

1. A general treatment consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission.

SECTION 15: RULES REGARDING HISTORIES AND PHYSICALS

1. The medical history & physical exam must be completed no more than 30 days before or 24 hours after admission for each patient. When the medical history and physical exam is completed within 30 days before admission, an updated medical record entry documenting an examination for any changes in the patient's condition must be completed by the surgeon and documented in the patient's medical record within 24 hours after admission, but before surgery or applicable procedure.
2. A history and physical needs to be completed in the standard hospital format, as approved by the Executive Committee as follows:
 - Chief Complaint
 - History (detail) or present illness
 - Past Medical History (include current medications and allergies)
 - Family and Social History (if relevant)
 - Physical Exam to include: General Exam, Vital Signs, HEENT, Heart, Lungs, Chest, Abdomen, Extremities, Neurological, and any other exam deemed relevant.
 - Initial Impression/Reason for Admission
 - Plan for Treatment
3. For patients being admitted/transferred to the Skilled Nursing Facility, the discharge summary from the Inpatient stay may be used as the history and physical **if** done within 24 hours of admission/transfer to Skilled Nursing Facility.

The emergency department exam/records, provided they include all of the required H&P elements, may be used as the admission/inpatient H&P for patients admitted by the emergency department physician.

4. Patients admitted to the Long Term Care unit must have a history and physical examination performed and recorded no earlier than twenty-four (24) hours prior to admission or later than seventy-two (72) hours after admission. A history and physical completed within thirty (30) days prior may be used provided:
 - A. There is a summary of the resident's condition and course of care during the interim period and the summary includes the current physical/psychosocial status of the resident. This summary is completed within twenty-four (24) hours before admission or within seventy-two (72) hours after admission.
 - B. If the history and physical was performed by a licensed independent practitioner other than the attending physician and was performed within thirty (30) days prior to admit, then within twenty-four (24) hours before admission or within seventy-two (72) hours after admission, the attending physician must:
 - review the physical examination
 - conduct a second assessment to confirm the information and findings
 - update information and findings as necessary including a summary of the resident's condition and course of care during the interim period and the current physical/psychosocial status
 - an oral health assessment may be performed and documented within ninety (90) days prior to admission or within fourteen (14) days after admission.
 - C. For sub-acute patients, the attending physician or licensed independent practitioner (LIP) submits a history and physical within a time frame not exceeding twenty-four (24) hours before admission or forty-eight (48) hours after admission. A history and physical completed within thirty (30) days before admission or readmission is acceptable provided:
 - there is a summary of the patient's condition and course of care during the interim period, and
 - the current physical/psychosocial status within twenty-four (24) hours before admission or forty-eight (48) hours after admission is included.
 - D. If the history and physical was performed by a physician other than the attending LIP and that assessment was performed within thirty (30) days before admission, then within twenty-four (24) hours before admission or within forty-eight (48) hours after admission, the attending physician must:
 - review the physical examination
 - conduct a second assessment to confirm the information and findings
 - update any information and findings as necessary to include a summary of the patient's condition and course of care in the interim and the current physical/psychosocial status
 - record the findings in the record on admission or within seventy-two (72) hours following admit.

SECTION 16: PROVIDER ORDERS

1. All orders for treatment shall be entered into the electronic medical record by the practitioner. An exception to this rule occurs during system downtimes. Practitioners should follow downtime protocols during planned or unplanned

periods of downtime. *See also Medical Staff "Verbal & Telephone Orders" policy*

Computerized practitioner order entry (CPOE) rate of compliance will be considered at reappointment.

2. All verbal orders will be entered electronically and read back to the provider who must then confirm the order. The responsible Medical Staff member shall authenticate such orders within 30 days of when the patient is discharged. *See also Medical Staff "Verbal & Telephone Orders" policy*
 - a. The following people may accept/transcribe telephone/verbal orders:
 - 1) Registered Nurse
 - 2) LPN's
 - 3) HUCs may accept/transcribe telephone/verbal orders with the exception of orders for IV's, blood products, code status or medications.
 - b. The following people may accept telephone/verbal orders as they relate to their respective specialty:
 - 1) Licensed Pharmacists
 - 2) Clinical Psychologists
 - 3) Certified or Registered Medical Technologists
 - 4) Credentialed Cardiopulmonary Services personnel
 - 5) Certified or Registered Respiratory Therapists
 - 6) Licensed Physical Therapists
 - 7) Registered Speech Pathologists
 - 8) Registered Radiology Technicians
 - 9) Medical Social Service Workers
 - 10) Registered Dieticians
 - 11) Registered Recreational Therapists
 - 12) Registered Occupational Therapists
3. Telephone orders shall be considered and treated as verbal orders. Telephone orders from a physician's office, which are transmitted by someone other than the physician shall be construed and interpreted as coming from the physician. Hospital personnel accepting orders from the physician's office employees are to identify in the chart by name and title, the person from the office that is transmitting the order. A qualified hospital employee can request to validate an order with the responsible physician. *See also Medical Staff "Verbal & Telephone Orders" policy*
4. The physician order for medications is to outline the medications, dosage and interval for each medication. Orders for "continue home meds and meds as at home" will not be accepted.
5. Patients will receive physician discharge instructions prior to discharge.

SECTION 17: RESIDENTS WRITING ORDERS

1. Hospital approved Residents are authorized to enter orders on patients hospitalized and assigned to their care. While each order need not be countersigned, there shall be sufficient documentation to demonstrate the supervision of the patient's care by a Medical Staff member.

ARTICLE IV EMERGENCY DEPARTMENT

SECTION 1: GENERAL PLAN FOR EMERGENCY SERVICES

1. Emergency department coverage is provided twenty-four (24) hours per day by members of the Medical Staff, Allied Health Professionals and/or contracted physicians who have been granted privileges.

SECTION 2: JUSTIFICATION OF EMERGENCY ADMISSION

1. Practitioners admitting emergency cases shall be prepared to justify to Hospital Administration and the President of the Medical Staff or designee, that the emergency admission was a bone fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded in the patient's electronic medical record as soon as possible after admission.

SECTION 3: SELECTING PHYSICIAN BY PATIENT UNDER EMERGENCY SITUATIONS

1. A patient to be admitted on an emergency basis who does not have a personal physician may select any Medical Staff member in the applicable service to attend him/her. Where no such selection is made, a member of the Medical Staff will be assigned to the patient based on the on-call list.
2. A "no-doctor" patient is a patient presenting to the emergency department for care and possible subsequent admission who has no personal physician or a physician who is not a member of the Medical Staff of MercyOne Oelwein Medical Center.
3. If a physician who does not have privileges to admit and care for patients at MercyOne Oelwein Medical Center contacts a member of the Medical Staff to see and care for this patient, the patient's care is a transfer of care from the primary physician to the consulting physician. This is a transfer of care to a specific physician and these patients will not be considered to be unassigned.

SECTION 4: GUIDELINES FOR MEDICAL STAFF MEMBERS SEEING PRIVATE PATIENTS IN THE EMERGENCY DEPARTMENT

1. Each Medical Staff member will furnish the Emergency Department physician and/or staff with the following directions as to the private and/or undoctored patients of such physician who present themselves to the Emergency Department:
 - A. The Emergency Room physician is to see all such patients and the private physician is to be notified only if admission is necessary, or
 - B. Unless there is specific instruction by the private physician for the Emergency Department to see a patient, the Emergency Department nurse is to notify the private physician when such physician's patient presents himself at the Emergency Department, at which time the private physician will decide if such patient should be seen by the

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Emergency Department staff, or

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- C. The Emergency Department staff in all situations will take action should the patient's condition warrant, or
- D. If, after examining an undoctored patient or a patient who has a physician who is a member of the Medical Staff, the Emergency Department physician determines that the patient is a candidate for admission, he shall notify the attending physician and inform him of pertinent medical information regarding the patient's condition, as well as his recommendation to admit the patient. If the attending physician concurs with this recommendation to admit, the responsibility for the medical care of the patient shall be transferred to the attending physician. Either the attending physician or the Emergency Department physician is responsible for supplying admitting orders.
- E. If the attending physician does not concur with the recommendations of the Emergency Department physician to admit, the Emergency Department physician shall:
 - objectively summarize to the attending physician his/her reasons for recommending the admission to assure there is no misunderstanding;
 - specifically inform the attending physician that the responsibility for further care of the patient is now being transferred to the attending physician;
 - document all aspects of the case in the medical record, including the fact that the responsibility has been transferred to the attending physician; and
 - the attending physician must physically see and evaluate the patient prior to discharging the patient from the Emergency Department under these circumstances.
- F. If the attending physician refuses to come to the Emergency Department to see and evaluate the patient, the Emergency Department staff shall:
 - notify the charge nurse of the situation
 - forward the chart and all information relating to the case to the President of the Medical Staff by the end of the shift for review the next day
 - for an unassigned (undoctored) patient, the Emergency Department staff will contact the President of the Medical Staff for instructions for the care of the patient
 - the Emergency Department physician may call any private physician regardless of instruction if deemed necessary.

SECTION 5: EMERGENCY DISASTER PLAN

- 1. There shall be a plan for care of mass casualties at the time of major disaster, based upon the hospital's capabilities in conjunction with other emergency facilities in the community. The Emergency Preparedness Committee shall develop it. The Medical Staff and Governing Body shall approve the plan.

SECTION 6: ELEMENTS OF THE EMERGENCY DISASTER PLAN

- 1. The disaster plan shall make provision within the hospital for:
 - A. The availability of basic utilities and supplies, including gas, water, food, and essential medical and supportive materials.
 - B. Notifying and assigning personnel
 - C. Unified medical coordination by the President of the Medical Staff or

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his/her designee

- D. Conversion of usable space into clearly defined areas for efficient triage, patient observation and immediate care
- E. Prompt transfer, after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definite care, when necessary
- F. A special disaster medical record that accompanies the casualty as he is moved
- G. Procedures for the prompt discharge or transfer of patients in the hospital who can be moved without jeopardy
- H. Maintaining security in order to keep relatives and curious persons out of the triage area
- I. A public information center and assignment of public relations liaison duties to a qualified individual.

SECTION 7: EMERGENCY DISASTER DRILL

- 1. The disaster plan should be rehearsed at least twice per year. Participation with other community EMS agencies is desirable. The drills should be as realistic as possible and involve Medical Staff as well as all hospital staff. Actual evacuation of patients is optional. There should be a written report and evaluation of all drills.

**SECTION 8: ADMINISTRATION OF MEDICATIONS IN THE
EMERGENCY DEPARTMENT**

- 1. After assessing a patient's condition, a nurse, pursuant to an order by a physician, [providing the physician has privileges at MercyOne Oelwein Medical Center may administer:
 - A. Technical or pharmacological preparation for a procedure
 - B. Serial antibiotic injections
 - C. Rhogam, micro-gam injections
 - D. IV maintenance for outpatient serial pharmacological therapy to a patient in the Emergency Department
 - E. Non-scheduled substances not listed above and scheduled substances (i.e., Classes 2, 3, 4, and 5 of the Controlled Substances Act) of any kind shall be administered in the Emergency Department only if the patient has been physically examined during the visit by a physician in the Emergency Department.

**SECTION 9: PROVISION OF EMERGENCY DOSES FROM THE
EMERGENCY DEPARTMENT**

- 1. After assessing a patient's condition, a nurse, pursuant to an order made by the patient's physician, may provide a pre-packaged emergency supply of non-scheduled medication to a patient only if the patient physically presents him/herself to the Emergency Department staff.
- 2. Scheduled substances may be provided in the Emergency Department only if a physician in the Emergency Department has physically examined the patient during that visit.
- 3. It should be remembered that the take home doses are intended for emergency situations only.

SECTION 10: TRANSFER OF EMERGENCY PATIENTS

1. Documentation of the process by which emergency patients are transferred from this hospital to another healthcare facility must demonstrate full compliance with Joint Commission standards and COBRA. Healthcare providers are expected to comply with the Wheaton Franciscan Healthcare *Patient Transfer* policy.

Those healthcare providers deemed as qualified medical persons (QMP) to perform medical screenings at MercyOne Oelwein Medical Center include Emergency Department physicians and emergency room registered nurses.

2. The evaluation and stabilization of patients before transfer shall be documented in the medical record by stating:
 - A. A chronology of events that have taken place in the case
 - B. Measures taken and/or treatment implemented
 - C. A description of the patient's response to treatment, and
 - D. The results or measures that have been taken to prevent further deterioration.
3. No patient shall be transferred arbitrarily from MercyOne Oelwein Medical Center to another facility before completion of emergency treatment and stabilization of the patient if emergency care can be provided adequately at MercyOne Oelwein Medical Center. Documentation of this provision will reflect the transfer was not conducted as a result of any of the following:
 - A. Ability to pay or method of payment
 - B. Amount of time required for emergency treatment
 - C. Prognosis (i.e., as critical or terminal)
 - D. Immigration status
 - E. Sex, race, creed or national origin
 - F. Criminal status
4. The transfer of a patient may be initiated before, but not carried out until after, the receiving facility has consented to accept the patient. Required documentation includes:
 - A. Patient identification
 - B. The receiving facility, accepting physician, and the date and time of acceptance
 - C. The information given to the receiving facility
 - D. The suspected diagnosis
 - E. The patient's stabilized condition
 - F. The name of the person at the hospital whom originally received the patient.
5. At the time the patient is transferred to another facility, a current medical record (or copy of it) shall accompany the patient. The record will include a summary of all pertinent events, actions, diagnoses, and treatment, including a record of:
 - A. The authorization of the transfer
 - B. The receiving hospital's acceptance of transfer
 - C. The names of all personnel involved in the transfer
 - D. Information describing responsibility for the patient during the transfer.
6. For purposes of documenting the ongoing, systematic surveillance and review of

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emergency transfers, all documents, including any register, roster, medical records and so forth shall be reviewed by verifying:
- A. The name of the patient transferred
 - B. The stabilization of the patient prior to the transfer
 - C. The record of acceptance from the receiving hospital and the name of the person responsible for accepting the patient
 - D. A record of the information sent with the patient (i.e., a copy of the ER record), and
 - E. Any unusual events that occurred during the transfer.
7. If a physician is not physically present in the emergency department at the time an individual is transferred, the QMP may sign a certification of benefits versus risk form after consultation with a physician who agrees with the certification and subsequently countersigns the certification. The physician's countersignature needs to be obtained within 30 days of the QMP's prior certification.

ARTICLE V: TRAUMA SERVICES

SECTION 1: TRAUMA ALERT PROCESS

1. The trauma alert process is developed, reviewed and revised by the Trauma Services Committee. It shall encompass all necessary elements to comply with the Iowa State Department of Health Standards. The trauma alert process description is located in the Emergency Department.

SECTION 2: COMMITTEE STRUCTURE

1. The Trauma Services Medical Director is the Chair of the Trauma Services Committee. The Medical Director reports to the Medical Staff Executive committee. The Director reviews and communicates recommendations concerning requests for trauma privileges to the Medical Staff. The Director is responsible for policy setting and coordination of the disposition of the patients.

ARTICLE VI MEDICAL AND SURGICAL CONSULTATION

SECTION 1: CONSULTATION GUIDELINES

1. The consultant shall document his findings and recommendations to become a part of the chart in every such case. Except in an emergency, consultation should be considered in the following situations:
 - A. When the patient is not a good risk for operation or treatment
 - B. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed
 - C. Any procedure for which the practitioner does not have full privileges
 - D. Where there is doubt as to the choices of therapeutic measures to be utilized
 - E. In unusually complicated situations where specific skills of other practitioners may be needed
 - F. In instances in which patient exhibits severe psychiatric symptoms
 - G. When requested by the patient and/or family.

SECTION 2: PHYSICIAN'S RESPONSIBILITY TO REQUEST CONSULTATION

1. The attending practitioner is solely responsible for requesting consultation when indicated and for calling in a qualified consultant. The requesting practitioner should not rely solely on the electronic medical record for communicating the request for consultation. Two types of consultations exist by definition. These are STAT and Routine. The reason for the consultation must be documented at the time of consultation.
 - A. STAT consultations require direct peer-to-peer communication at the time of the consultation request and again after the consultant has seen the patient to provide his/her recommendations. This facilitates optimal care and any necessary immediate interventions.
 - B. Routine consultations require evaluation by the consultant within twenty-four (24) hours of the consultation request.
 - C. All orders for consultations must specify the name of the group and/or physician being requested to do the consult.
See also "Provider to Provider Communication" Policy

SECTION 3: PHYSICIAN QUALIFIED FOR CONSULTATION

1. A consultant must be qualified based on his individual training, experience, and competency in the field for which the opinion is sought. If the consultant is not a member of the Medical Staff, he must be given temporary privileges.

ARTICLE VII SURGERY

SECTION 1: DESCRIPTION OF OPERATIONS

1. All operations performed shall be fully described by the attending surgeon.
2. The following are the types of elective invasive procedures performed in a designated and equipped area of the hospital by physicians with appropriate privileges:
 - A. Biopsies (e.g., breast lymph nodes, liver, lung, kidney, prostate, etc.)
 - B. Removal of cysts, lipomas, lesions
 - C. Wound care (e.g., debridement, incision and drainage)
 - D. Revision of simple scars, skin grafting
 - E. Laser procedures
 - F. Hemorrhoid treatment
 - G. Hysteroscopies, LEEP procedure(s)
 - H. Pain management: epidurals, pump refills
 - I. Diagnostic tests: lumbar puncture, bone marrow, urologic (EMG, CMG), ultrasound, cystoscopy, catheterizations, arteriography, myelography
 - J. Swan Ganz catheter insertion
 - K. Paracentesis
 - L. Thoracentesis, chest tube insertion
 - M. Intubation
 - N. Excision biopsies
 - O. Angiography, image guided biopsies, CT scans
 - P. Mammography localization

SECTION 2: SURGICALLY REMOVED TISSUE TO PATHOLOGIST

1. All specimens removed during a procedure shall be sent to the MercyOne Oelwein Medical Center pathologist, who shall make such examination as he may consider necessary to arrive at a pathological diagnosis, with the following exceptions:
 - A. Specimens that by their nature or condition do not require more than gross examination, such as disc fragments, toe nails, adenoids, tonsils, cartilage fragments (including meniscus), ureteral stents, scars cataract, orthopedic appliance, foreign, body, or portion of a rib or tissue removed only to enhance operative exposure
 - B. Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements
 - C. Traumatically injured members that have been amputated and for which the examination for either medical or legal reasons is not deemed necessary
 - D. Foreign bodies (e.g., bullets) that for legal reasons are given directly, in the chain of custody, to law enforcement representative
 - E. Specimens known to rarely, if ever, show pathological change, the removal of which is highly visible post-operatively, such as the foreskin from the circumcision of a newborn infant

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F. Teeth, provided the number (including fragments) is recorded in the

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medical record

- G. Specimens obtained during joint procedures and podiatric procedures (i.e., bone fragments, etc)
 - H. Placentas (held for 48 hours in laboratory)
 - I. Femoral head, if x-ray clearly documents arthritis
2. Whenever tissue is removed and not forwarded to the pathology department, this is to be documented by the operating surgeon on the patient's hospital record
 3. All specimens will remain the property of the hospital

**SECTION 3: INFORMATION NEEDED TO SCHEDULE INVASIVE
 RADIOLOGICAL PROCEDURES**

1. A history and physical report must be on the chart prior to the beginning of the following radiological procedures:
 - A. Percutaneous drainage procedures
 - B. Percutaneous biopsies

ARTICLE VIII GENERAL RULES OF THE MEDICAL STAFF

SECTION 1: OUT OF AREA PHYSICIAN/DETERMINATION OF PHYSICIAN TO ATTEND PATIENTS

1. Each member of the Medical Staff who does not reside in the immediate vicinity shall name a member of the Medical Staff who is a resident in the area who may be called to attend his patients in an emergency, or until he arrives. In case of failure to name such an associate, the President of the Hospital, President of the Medical Staff, or Chairman of the Department concerned, shall have authority to call any member of the active staff in such an event.

SECTION 2: AUTOPSIES

1. It shall be the responsibility of Medical Staff members to secure autopsies whenever possible. An autopsy may be performed only with a written consent, signed in accordance with state law. All autopsies shall be performed by a pathologist, or by a practitioner with appropriate privileges. Provisional anatomic diagnoses shall be made available to the clinician within 24 hours and the complete protocol shall be made a part of the record within 4 weeks.

SECTION 3: PROCEDURE INVOLVING PATIENT DEATH CLOSE TO ADMISSION

1. If a patient dies in the emergency department or immediately after admission in an unexpected manner and without history of relevant medical supervision, a death note summarizing the facts known should form a part of the record. It is the responsibility of the physician assigned to the patient to notify the Medical Examiner if the case meets the criteria of law or regulation.

SECTION 4: OXYGEN REMOVAL FOR TRANSPLANT

1. Prior to organ transplantation procedures involving brain wave death donors, a written consent form must be obtained from the next-of-kin and a statement of death should be in the medical record before actual organ removal is begun.

SECTION 5: REQUEST FOR RADIOLOGICAL SERVICES

1. All requests for radiological services should contain sufficient information from the requesting practitioner identifying the reason for the examination in order to assist the radiologists in making their diagnosis.

SECTION 6: APPROVAL OF MEDICATION AND DRUGS/CLINICAL INVESTIGATION

1. All drugs and medications administered to patients shall be those listed in the latest edition of the United States Pharmacopoeia, National Formulary, American Hospital Formulary Service, or AMA Drug Evaluations.
2. Drugs for bone fide clinical investigation may be exceptions. These shall be

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used in accordance with the statement of principles involved in the use of
investigational drugs in hospitals and all regulations of the Federal Drug
Administration.

**SECTION 7: NURSES REPORTING OF CONCERNS
REGARDING PATIENT CARE**

1. If a nurse has reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, such shall be called to the attention of the President of the Medical Staff for resolution.

SECTION 8: ALLIED HEALTH PROFESSIONALS (AHP)

1. Physicians employing Allied Health Professionals functioning within MercyOne Oelwein Medical Center must file an application for consideration, recommendation and approval as described in the Medical Staff Bylaws.
2. Physicians employing or otherwise assigned responsibility to supervise Allied Health Professionals are responsible for the clinical activities and performance of the AHPs.

SECTION 9: CASE PRESENTATION NOTIFICATION

1. When specific medical records are to be presented at a staff meeting, the medical staff member on the case is to be notified if any of his/her cases are to be discussed at the meeting, and if at all possible, he/she should be present.

SECTION 10: INFECTIOUS CASES

1. Infectious cases at the hospital shall be handled in accordance with the recommendation of the Infection Control Committee as approved by the Medical Staff Executive Committee.
2. Infectious disease shall be reported to the appropriate authorities as required by law or regulation.
3. The guidelines of the Communicable Disease Center shall be followed with regard to the reporting of infections and deciding which infections are in-hospital and which are community acquired.

SECTION 11: DISCONTINUATION OF DRUGS

1. Schedule narcotics that are ordered without time limitation of dosage shall be automatically discontinued after 5 days, unless otherwise indicated by manufacturer.
2. Antibiotics ordered without time limitation shall automatically be discontinued after 10 days, unless otherwise indicated by manufacturer.
3. The physician will be asked to renew the medication order 24 hours prior to its discontinuation and will be notified in writing at the time the medication is discontinued.

SECTION 12: LABORATORY TESTS

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1. Laboratory tests will be accepted from any laboratory approved by the College of American Pathologists or Joint Commission on Accreditation of Healthcare Organizations.
2. Orders for non-invasive laboratory test will be accepted from practitioners in accordance with the *Outpatient Orders Policy*

SECTION 13: CHEST X-RAYS

1. Physicians who have privileges at MercyOne Oelwein Medical Center may only order X-ray testing for inpatients.
2. Orders for non-invasive x-ray testing will be accepted from practitioners in accordance with the *Outpatient Orders Policy*

SECTION 14: EMERGENCY COVERAGE

1. All members of the Medical Staff shall make arrangements for other practitioners to take call and provide for emergency coverage in the absence of the member.

SECTION 15: PRACTITIONERS REQUESTING CONSULTANT COMING TO ASSIST WITH A NEW PROCEDURE

1. A Medical Staff member who wishes to invite an outside medical expert to assist him/her with a new procedure must first demonstrate that the outside expert practitioner, based upon his education, training, experience, demonstrated competence, judgement, and references to other relative information is capable of performing the procedure upon a patient.
2. The outside medical practitioner must submit information showing that he is a member in good standing of the Medical Staff of another JCAHO accredited hospital, and complies with MercyOne Oelwein Medical Center's established insurance and credential requirements, with respect to practitioners performing individual procedures.
3. The Medical Staff member who wishes to invite an outside expert to assist with a new procedure must first demonstrate that they have completed the necessary didactic and laboratory training and is now ready to begin doing the procedure on patients.
4. The MercyOne Oelwein Medical Center practitioner must be prepared to manage potential intra- operative and post-operative problems associated with the procedure.
5. The patient must, in writing, be aware that the MercyOne Oelwein Medical Center practitioner is learning a new procedure and that the outside consultant will be there as an active participant in the surgery, and that in fact, the consultant may be doing all or some of the case.
6. If the procedure in question is investigational, rather than FDA approved, it must go through a quality investigational process prior to the procedure being performed.

7. In order to obtain a properly documented informed consent, the following information is necessary to be provided with consent:
 - A. A fair explanation of the procedures to be followed, and their purpose, including identification of any procedures which are of a teaching nature or experimental;
 - B. A description of any attendant discomforts and risk reasonable to be expected;
 - C. A description of benefits reasonable to be expected;
 - D. A disclosure of any appropriate alternative procedures that might be advantageous for the patient;
 - E. An offer to answer any inquiries concerning the procedures;
 - F. An instruction that the patient is free to withdraw his consent and to discontinue participation in the procedure at any time without prejudice to the patient.

SECTION 16: VENTILATOR MONITORING

1. Oxygen saturation monitoring will require the following:
 - A. All patients undergoing continuous oximetry monitoring require a baseline CBG.
 - B. Abnormalities in CBG results should be re-evaluated at appropriate intervals as dictated by clinical and laboratory findings.
 - C. If oximetry is utilized greater than or equal to 72 hours, a CBG should be obtained every 72 hours.

SECTION 17: VENTILATOR MANAGEMENT

1. Only physicians who have been granted appropriate privileges may manage acute ventilator patients.
2. A monitored bed is the most appropriate setting for acute ventilator care. It is recognized that in some cases alternative settings should be considered if long term ventilator care is anticipated and staffing levels, knowledge, skills and ability are available.
3. The physician managing a ventilator patient is required to state the following information in the progress notes:
 - A. Diagnosis or diagnoses
 - B. Prognosis
 - C. A treatment plan including medications, surgical intervention, termination of ventilator assistance, and long term care.
 - D. Family preference (i.e., status of the family in decision making)
 - E. This plan must be updated at least every 7 days.
4. Nursing is to notify care coordination for assistance in post hospital planning if the patient is determined to be a long-term ventilator patient.
5. The quality improvement and utilization review committees will monitor these patients to ensure planning and care is appropriate.

SECTION 18: RESTRAINT & SECLUSION

1. Providers comply with the Wheaton Franciscan Healthcare Patient Focus policy and procedure as it relates to restraint and seclusion.

SECTION 19: MALPRACTICE LIABILITY INSURANCE COVERAGE

1. Each Medical Staff Member and Allied Health Professional needs to hold malpractice liability insurance approved by the Iowa Insurance Commissioner or other evidence of financial responsibility approved by the board of directors.
2. Medical Staff Members and Allied Health Professionals, with the exception of non-operating general dentists, shall show evidence of current malpractice insurance coverage or other evidence of financial responsibility at a minimum of \$1,000,000/\$3,000,000. A copy of the certificate of insurance, or copy of the policy, showing such minimum coverage, is required in order to obtain or maintain Medical Staff membership/privileges.
3. Non-operating general dentist members of the Medical Staff shall show evidence of current malpractice insurance coverage or other evidence of financial responsibility at a minimum of \$500,000/\$500,000. A copy of the certificate of insurance, or copy of the policy, showing such minimum coverage, is required in order to obtain or maintain Medical Staff membership/privileges.

SECTION 20: MEETING ATTENDANCE

1. Members of the Medical Staff shall attend at least 50% of meetings of the Medical Staff and to committees to which appointed.

ARTICLE IX **ORGANIZED HEALTH CARE
ARRANGEMENTS AND SHARING OF
INDIVIDUALLY IDENTIFIABLE HEALTH
INFORMATION BY THE HOSPITAL AND ITS
MEDICAL AND ALLIED HEALTH STAFF
MEMBERS.**

**SECTION 1: GENERAL BACKGROUND ON HIPAA PRIVACY
RULES**

1. The Health Insurance Portability Act of 1996 and its implementing regulations ("HIPAA"), among other things, regulate how providers can use and disclose individually identifiable protected health information ("PHI") with one another.
2. HIPAA also requires a provider with a direct treatment relationship with an individual (including, among others, hospitals, providers and allied health professionals) to provide the individual with a notice of its privacy practices. The notice must afford the individual with adequate notice of the provider's uses and disclosures of PHI, the individual's rights and the provider's responsibilities with respect to PHI. The notice of privacy practices must be furnished to the individual upon the first service delivery, except in emergency situations, in which case it may be provided as soon as reasonably practicable.
3. HIPAA further requires a provider with a direct treatment relationship with an individual to make a good faith effort to obtain a written acknowledgment of the individual's receipt of the provider's notice of its privacy practices. If the acknowledgment cannot be obtained, the provider must document in good faith its efforts to obtain such acknowledgment and the reason why the acknowledgment was not obtained.
4. Under HIPAA, if two or more providers (including a hospital and its medical staff) are part of the same "Organized Health Care Arrangement" ("OHCA"), they may issue a joint notice of their privacy practices and obtain a joint acknowledgment from the individual. Accordingly, for patients treated through the OHCA, only one notice and one acknowledgment are required for all of the providers in the OHCA
5. Notwithstanding, under HIPAA, if a provider is a member of an OHCA, and that same provider also has his or her own private practice, and his or her privacy practices in his private office are different than that of the OHCA, for patients that provider treats outside of the OHCA, the provider must still deliver his/her own notice of privacy practices and obtain his/her own acknowledgement.

SECTION 2: HOSPITAL AND MEDICAL STAFF ARE AN OHCA

1. The Hospital and its Medical and Allied Health Staff Members (referred to for purposes of this Article 11 as "Members") operate as an OHCA in that they provide direct patient care services through clinically integrated settings (e.g., inpatient or outpatient hospital settings and/or other hospital-based clinic settings).

**SECTION 3: JOINT ACKNOWLEDGMENT AND JOINT NOTICE OF
PRIVACY PRACTICES**

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1. Members treating patients at any of the clinically integrated settings of the Hospital's OHCA shall use a joint acknowledgment and joint notice of privacy practices, as described herein.
2. The joint acknowledgment and joint notice of privacy practices shall be in such forms as are designated by the Hospital and such joint acknowledgment and joint notice of privacy practices shall meet the requirements of HIPAA.
3. Each Member shall abide by the terms of the joint notice of privacy practices with respect to PHI created or received by such Member as part of its participation in the Hospital's OHCA.
4. Each Member shall take reasonable steps to ensure the privacy and security of all PHI, including PHI created, used, transmitted or maintained as part of the Hospital's OHCA. Such reasonable steps should be in place for all PHI, in all forms, including verbal, written and/or electronic (including but not limited to e-mail, Personal Data/Digital Assistants and other means).

SECTION 4: CORRECTIVE ACTION

1. Failure of any Member to comply with the requirements of this Article may subject such Member to corrective action as provided in the Medical and/or Allied Health Staff Bylaws.

SECTION 5: DISCLAIMER OF LIABILITY

1. Notwithstanding the foregoing OCHA relationship described in this article, the hospital hereby explicitly disclaims any third parties, whether under theories of apparent agency or any other theory of liability, for the ACTS and omissions of its members.

SECTION 6: EFFECTIVE DATE

The terms and conditions of this Article shall become effective upon approval by the Board of Directors.

ARTICLE X Approval and Adoption

SECTION 1: MEDICAL STAFF

1. Rules and Regulations of the Medical Staff were recommended to the Board of Directors for approval by the Medical Staff Executive Committee in accordance with and subject to the Medical Staff Bylaws and the Bylaws of MercyOne Oelwein Medical Center.

Date: March 18, 2021

SECTION 2: BOARD

1. These Rules and Regulations of the Medical Staff were approved by the Board of Directors after considering the recommendation of the Medical Staff Executive Committee in accordance with and subject to the Bylaws of MercyOne Oelwein Medical Center.

Date: April 1 2021

Critical Access Hospital Committee Review/Approval: 5/25/2020

Revised:

4827-5178-3181v2 2/7/2012 11:11 AM

11/01, 1/03, 5/03, 6/03, 8/03, 8/05

4/06 revision to Medical Records – Section 13

10/06 revision to Medical Records – Entire Section

12/06 revision to Emergency Department – Section 10

4/07 revision to Section 19 – History and Physicals and section 20 –Verbal orders (Feb MEC Meeting, April Board)

4/07 Revision to Emergency Department – Section 10 – Item 7. Change from 28 days to 30 days. (April MEC, April Board)

10/07 Deletion of pre-anesthesia assessment to serve as the 24-hour H&P update prior to surgical or invasive procedures.

1/08 – VORB/TORB need to be authenticated within 30 days post discharge and responsibility for 24 hr H&P update is the surgeon.

2/08 – H&P not required prior to administration of local anesthesia 2/09

– Revised Medical Records Delinquency policy, Section 13 11/11-

Revised to add Allied Health Professionals for ER Staffing

01/12 – Removal of Article VII, Section 8: Anesthesia Provider on Call

02/13 – Section 4. Update to include PA's and NP's to perform a daily written progress note 10/2014

- revised Section 19, item 5.

9/2017 – remove references to paper charting and other paper processes; remove irrelevant sections related to Surgery, Anesthesiology, OB, etc.

12/7 requirements of discharge summary on all inpatients added except those under observation for <48 hours